

PM Form 7.3.3

Medical Director/Clinical Director Seclusion and Restraint Monthly Review Report

Level I facility: (Please check one)

- CCC sub-acute – Pineview
- Mingus Center
- MMHC sub-acute
- TGC - ARTC
- TGC Inpatient Psychiatric Hospital
- WYGC sub-acute - Hillside

Month and Year being reviewed: _____

COMPLETE SECTION 1 OR SECTION 2

SECTION 1:

Date of Incident	Client ID	Start Time of S/R	End Time of S/R

I attest that the above seclusion and restraint incidents have been reviewed.

Medical Director/Clinical Director Signature

Date

SECTION 2:

There were no seclusion or restraint incidents to be reviewed.

Medical Director/Clinical Director Signature

Date